

I'VE SEEN ENOUGH!

MY LIFE AND TIMES IN HEALTH CARE LAW AND POLICY

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THE INVITATION TO PARTICIPATE in this symposium encouraged prospective authors, if they wanted, to comment on both the origins of health care law as a scholarly and practice specialty and their personal experiences in the field. Because my career as a legal scholar, beginning in the mid-1960s, has coincided almost perfectly with the field's emergence and maturation, I feel comfortable in offering this autobiographical essay, hoping it will be of some interest and value to those who missed the excitement, and possibly some of the lessons, of the field's formative years.¹ The essay also includes reflections on the current state of health care law and policy and on some intellectual blind spots that influence thinking in the field.

Serendipity alone accounts for my making a career of critically studying the legal environment of the U.S. health care industry.² Unlike the highly prepared young law teachers of today, I embarked on an academic career with no specific scholarly agenda in mind. In fact, one of the attractions of the job offered at Duke was that I would not be expected to plunge immediately into research and writing of my own. Instead, my initial appointment contemplated that, in addi-

[†] Professor of Law and William Neal Reynolds Professor of Law (Emeritus), Duke University. Given the nature of this essay, I have had to refer my own work even more than usual. Rather than citing each item mentioned, however, or the many others that might have been, I have (with the permission of the editors) deemed it more efficient to call readers' attention to my bibliography accessible through the Duke Law School website: <http://www.law.duke.edu>.

[‡] At the author's request, some of this article's formatting is inconsistent with Bluebook rules and *Health Matrix* style policies.

¹ I was also tempted, I admit, by the chance to use the essay's main title, which once occurred to me as a great one for somebody's autobiography—not mine, but someone's.

² I wonder how many other legal scholars working in the health care field conceive their purview in just this global way. Some, I sense, focus less on trying to understand how law and the legal system frustrate, or might better facilitate, the industry's good overall performance and more on either vindicating individual rights or simply addressing discrete legal issues as they arise.

tion to teaching such subjects as antitrust, regulated industries, securities regulation, and administrative law, I would serve for a few years as faculty editor of Duke's venerable quarterly, *Law and Contemporary Problems (L&CP)*. The assignment to produce in each issue a symposium of commissioned articles on a general topic I would select appealed to me precisely because, although I had already published some substantial practitioner-oriented things (including a book on deferred compensation plans and articles on federal tax liens and employee stock options), I had not yet identified a field of long-term scholarly interest. I have always considered it fortunate that, in my early years in academe, I had the opportunity to dabble in many fast-moving areas of law and policy and to learn from experts in many disciplines, while honing my own writing skills in editing their work.³

I first stumbled into law and medicine (as the field was then called) when the dean suggested that I prepare an *L&CP* symposium in conjunction with Duke's medical school. That project, which resulted in a 1967 issue entitled "Medical Progress and the Law," required more than the usual amount of substantive immersion in the field because several of the papers I commissioned were of disappointing quality, forcing me to scramble either to improve them, if possible, or to find last-minute replacements. This early exposure to the intersection of law and medicine would have led me no further into the field, however, if individuals in the Department of Health, Education and Welfare (HEW) had not been looking for a way to stimulate legal scholarship related to health care. Because the *L&CP* symposium bearing my name as editor was the precisely the kind of thing they hoped to encourage, I received an exploratory phone call from Laurence Tancredi, a young physician staffer at HEW (who later, with my encouragement, got a law degree at Yale and became himself a significant early player in the field of health care law). Our conversations led ultimately to a modest contract under which I undertook to start some balls rolling in health law scholarship. (The subsequent outpouring of such scholarship suggests—*post hoc, ergo propter hoc*—that our little project paid huge dividends.)

Under my contract with HEW, I created in 1969 the interdisciplinary Committee on Legal Issues in Health Care, which operated until 1974 and included such leading figures from the legal world as Guido Calabresi, William Curran, Frank Grad, and Nathan Hershey as well

³ Although I gave up the editorship of *L&CP* in 1970 (regrettably, it no longer has a faculty editor), I have had many later occasions to write for it and to edit additional symposia. Indeed, since *L&CP*'s inception in the same year I was born, I have published more pages in it than any other author.

as such other luminaries as Henry K. Beecher, Reuben Kessel, Louis Lasagna, and David Mechanic. The memoranda we prepared to elicit the interest of law review editors in health care topics resulted in the publication of a number of student-written articles and also led to my own first publication in the health care field, a 1970 article in *Science* entitled "Compensating Persons Injured in Human Experimentation." That article, a simple application of Calabresi's theorizing about the potential value of strict liability in optimally deterring accidents, also revealed my emerging interest, developed in part while editing *L&CP*, in law and economics.

But even these early engagements with the health care field might not have been enough to inspire me to make a life-long commitment to health care scholarship. After all, the salient legal issues in health care in the late 1960s were still only the traditional concerns of law and medicine—malpractice, hospital liability, occupational licensure, prescription drug regulation, abortion, informed consent, and a variety of other questions that now fall under the heading of bioethics. These subjects, though certainly interesting to me, overlapped only a little with my long-term teaching interests in antitrust law and economic regulation and my developing scholarly interest in law and economics. It was only when I heard about the new interest among policy makers in health maintenance organizations (HMOs)—from two of Paul Ellwood's minions, at a memorable (to me) meeting at HEW in January 1970—that I began to see clearly how my fascination with competitive markets as a non-governmental way to promote and channel change and to resolve intractable trade-offs and conflicts in the society might have some practical bearing on U.S. health policy and inspire some useful legal scholarship.

This new dimension of my interest in the health care industry was first manifest in a landmark two-volume symposium in *L&CP* sponsored by the Committee on Legal Issues in Health Care and published in 1971. In addition to two provocative forewords in which I argued for the market alternative in health care as few others had yet done, that symposium included my first major article on a health care topic, a lengthy piece entitled "Health Maintenance Organizations and the Market for Health Services." If for no other reasons, that article was notable because it used the word *market* in its title—a word that had rarely, if ever, turned up in bibliographies concerning health care—and because it suggested why antitrust law was potentially relevant to the health care sector. Subsequent developments certainly bore out my instinct that viewing health care as a potentially competitive "industry," and not as a monolithic, professionally controlled "system," would prove fruitful as a foundation for future scholarly endeavor.

Looking back on my intellectual development in those years, I count it a benefit that I did not come up through the ranks in law and medicine, absorbing conventional values and wisdom along the way. Indeed, I think the health care field needed a perspective like the one I brought to it, since it appears to attract mostly persons with authoritarian/collectivist, rather than pluralist, leanings. Relatively few health law scholars, for example, seem willing or able to contemplate a legal system that, rather than focusing principally on achieving desirable substantive outcomes, concentrates on the integrity of the process through which people make consequential choices for themselves.⁴ Yet in the absence of a plenary prescriptive or regulatory regime established by legislation, the law's principal function is most appropriately viewed as maintaining an open, fraud-free market in which even intractable, value-laden choices can be made, as reliably as reasonably possible, by the people most nearly affected, acting either as individuals or in groups or through selected agents—professional or corporate, nonprofit or commercial, as the case may be.⁵

⁴ Interestingly, scholars who are skeptical about letting consumers make crucial choices about their own health care usually make exceptions for informed-consent situations and abortion, presumably because there are no corporate intermediaries and the operative values do not include economizing—they are quick to defend individuals' right to choose. As I would, too. But see note 10 *infra*.

⁵ To appreciate how hard it is for some legal scholars to imagine—let alone help foster and create—either a market for health care in which people truly choose for themselves or a legal system that does not in some way preempt the most important choices, see M. Gregg Bloche, *The Invention of Health Law*, 91 CAL. L. REV. 247 (2003). Bloche's article "challenges the proposition that we can resolve legal controversies in the health care sphere through traditional economic reasoning," *id.* at 253, which he understands to require consulting welfare economics "for clear answers to scientific and moral questions about medical care's efficacy and value that our society has not been able to resolve." *Id.* at 321. Bloche, it seems, cannot conceive of a legal system that concentrates on maintaining a workable market, with incentives that do not distort choices unduly, and that then accepts the results of that black-box process as presumptively appropriate—i.e., efficient. Nor does he appreciate that, just maybe, decisions that have no ultimately satisfying or universally correct answers are precisely the kind of choices that should be left in private hands, not resolved according to positive law. Moreover, Bloche, like many others in our profession, is quite comfortable with having non-accountable judges serve as the ultimate arbiters of policy and outcomes, rather than merely as interpreters of legislation prescribing specific rights or obligations or, in the absence of such positive law, as guardians and facilitators of processes that allow individuals and their selected agents to make the consequential choices. For example, Bloche's conclusion on the courts' role in inventing health care law includes the instruction that "when judges choose, *as they must*, between competing priorities, they should make the normative basis for their choices explicit." *Id.* at 321 (emphasis added). See also *id.* at 290-94 (viewing the function of judicial review of health plans' coverage decisions as ensuring economic rationality and neglecting the possibility of anything other than de novo review of such deci-

My *L&CP* article on HMOs attracted support from a foundation run by Ellwood, the originator of the HMO strategy, and enabled me to serve during a sabbatical year (1972-73) as a scholar in residence at the newly established Institute of Medicine (IOM) of the National Academy of Sciences. This sabbatical proved to be a unique opportunity to become acquainted with many insiders in the health policy community and to discuss competition's role and antitrust issues with them at a time before interest groups felt seriously threatened by these policy ideas and political lines hardened.⁶ It also led to my later involvement in a number of IOM activities, including service as the only legal scholar on its Board of Health Care Services from 1987 to 1997.

Among my projects during my year at the IOM was an article with Tancredi proposing a limited strict-liability approach to compensating certain iatrogenic medical injuries. This article, subtitled "A No-Fault Approach to Medical Malpractice and Quality Assurance," again reflected Calabresi's theories concerning the incentive effects of tort liability. The Havighurst-Tancredi proposal, which I developed further in later writing and which received some serious attention in the late 1970s,⁷ still strikes me as having at least as much merit as anything that has come since on the subject of medical malpractice reform.⁸

sions, such as review to ensure that the plan's interpretation of its contract was not unreasonable, arbitrary, or capricious); *id.* at 295 n.163 (indicating the author's comfort with courts deciding the legality of restraints of trade on the basis of their view of a restraint's probable effects on consumer welfare, not on the basis of its effect on *competition*, the process that the Sherman Act was intended to foster and protect).

⁶ Some might think it more than a coincidence that in 1939, at the age of six, I accompanied my father, also a law professor, to Washington on a sabbatical leave during which, working for Thurman Arnold in the Antitrust Division of the Justice Department, he helped to write the government's brief in *United States v. Am. Med. Ass'n (AMA)*, 110 F.2d 703 (D.C. Cir. 1940), the first appellate round of the famous antitrust case in which the AMA was convicted of conspiring against an early HMO. However, that case was virtually the only exposure my father ever had to either antitrust law or the health care industry, and I would swear that I came to my interests by the route described above, not through any parental influence. To be sure, my own son, Craig, who was himself six years old during my 1972-73 sabbatical, eventually developed an interest in health care. But that interest was purely journalistic—as a reporter covering the health policy beat (including the Clinton reform effort) in Washington in the early 1990s. In any event, he has now switched his focus to the music business, which he writes about in Nashville, Tennessee.

⁷ See Laurence R. Tancredi, *Designing a No-Fault Alternative*, *LAW & CONTEMP. PROBS.*, Spring 1986, at 277 (restating proposal and summarizing attention given to it).

⁸ My later work on the general theme of strict liability for iatrogenic injuries included a 1977 piece on liability for injuries caused by contaminated blood; that article also included a put-down of some foolishly overstated ideas about the destruc-

The IOM year also included service on an IOM committee that developed a provocative policy statement on HMOs (including a critical evaluation of the federal HMO Act of 1973)⁹ and participation in a National Institutes of Health task force considering the implications of the artificial heart.¹⁰ The sabbatical also gave me a chance to begin studying in depth the new regulatory programs then being put in place in an attempt to overcome the apparent problems generated by third-party payment for health care. My teaching and reading in the field of regulated industries had sensitized me to the destructive consequences of entry controls in other industries, thus making me skeptical about certificate-of-need (CON) requirements for health facilities and services. Sometimes called "health planning with teeth," CON regulation was sweeping the country in the early 1970s, in a movement that culminated in major federal health planning legislation in 1974.¹¹ Almost the first serious questions about CON regulation were raised in June 1972 at a conference I organized for the American Enterprise Institute for Public Policy Research (AEI)—beginning an association with AEI that proved highly valuable to me in later years. During my year at the IOM, I edited the AEI conference proceedings for subsequent publication and wrote a lengthy critique of CON laws for the *Virginia Law Review*. This work laid the groundwork for additional evaluations of regulatory initiatives in the health care sector throughout the rest of the decade and beyond.

Continuing government grants allowed me, throughout the 1970s and into the 1980s, to employ at Duke a series of younger colleagues

tiveness of the profit motive advanced in a much-too-well-received book, ROBERT M. TITMUSS, *THE GIFT RELATIONSHIP: FROM HUMAN BLOOD TO SOCIAL POLICY* (1971). The lessons drawn there concerning the legitimizing and incentive value of liability have a bearing, it now occurs to me, on recent experience with managed health care, as discussed in the text at notes 36-37 *infra*.

⁹ INST. OF MED., *HEALTH MAINTENANCE ORGANIZATIONS: TOWARD A FAIR MARKET TEST* (1974).

¹⁰ Clark C. Havighurst, *Separate Views of Professor Havighurst, in* ARTIFICIAL HEART ASSESSMENT PANEL, NATIONAL HEART AND LUNG INSTITUTE, *THE TOTALLY IMPLANTABLE ARTIFICIAL HEART* 231 app. D (1973). Although I very much enjoyed that foray into the technological future and the domain of bioethics, the cited statement shows that it left me unsatisfied by the ability of bioethics to frame questions and therefore disinclined to pursue future issues from that perspective. In general, I have long sensed that bioethics is too often an exercise in *noblesse oblige* and that the choices it so consistently insists that people be given come too late in the game, after they have become dependent patients and not at a time when they are still independent consumers with some reason to be concerned how their resources are spent.

¹¹ National Health Planning and Resources Development Act of 1974, Pub. L. No. 93-641, 88 Stat. 2225.

to work on various projects. Randall Bovbjerg launched his career in this way, exploring among other topics the conceptually important question whether medical care provided under the auspices of an HMO should be held, in malpractice cases, to the same costly legal standard of care that applies in the unconstrained fee-for-service sector.¹² A grant also helped to support a visit to Duke by James Blumstein in 1974-75, during which he and I wrote (with Bovbjerg's help¹³) a major article in the *Northwestern University Law Review* discussing "quality/cost trade-offs in medical care." The word *trade-offs* in the article's title signified the directness of our challenge to the conventional view that health care should be delivered only according to "need," without regard to cost. To this day, Blumstein and I remain surprised at how few of our colleagues in health care law, despite our graphic demonstration of the need to take the battle into "the quality/cost no man's land," have significantly acknowledged any need for the legal system to accommodate private economizing when anything other than pure "fat" might be cut. Mostly, it seems to us, health law scholars want to change the subject, from the appropriateness of allowing subsidized consumers to economize at the margin, to something they are more comfortable in discussing—the imperfections of the market for health care and the ineptitude of consumers as decision makers. I have always been struck how critics of my work, in easily discounting the utility of markets because they are imperfect, do exactly what they (usually inaccurately) accuse proponents of market-oriented policies of doing—namely, using the unrealistic textbook model of perfect markets, with its assumption of informed, rational choice, as the basis for choosing a policy strategy. Their faith in their own preferred mechanisms of social control—government, the courts, and professional standards—still strikes me as more naive by far than my idea that markets and consumers' appropriately subsidized choices might reliably guide the health care industry toward efficiency in its use of scarce resources. Indeed, the market strategy is most likely to fail not so much because of any inherent deficiencies of markets or consumer choice as because government and the legal system—which are far less effectively accountable to informed, rational voters than market actors are to informed, rational consumers—impede its realization by catering to special interests, by distorting incentives, by lim-

¹² Randall Bovbjerg, *The Medical Malpractice Standard of Care: HMOs and Customary Practice*, 1975 DUKE L.J. 1375.

¹³ The three of us collaborated on another major article that year, a piece in *L&CP* that addressed the symbolic importance of health spending and health policy under the title, "Strategies in Underwriting the Costs of Catastrophic Disease."

iting consumers' options, and by invalidating even rational economizing choices *ex post* in order to minimize apparent hardship.¹⁴

In the mid-1970s, health policy debates focused mostly on the need for and design of economic regulation for the health sector, including not only health-planning and CON programs and regulation of hospital prices but also various methods to control the overutilization of services. I was well positioned to recommend rethinking the desirability of regulating health care, both because I knew something about other industries' poor experiences with utility-type regulation and because I could visualize how an unregulated health care industry might work. My arguments were better received than they might have been at another time because many economists and some liberal critics were beginning to find much economic regulation to be highly problematic. The problem of industry "capture" of its own regulatory apparatus was soon seen to be not merely a potential problem in health care but, in the form of professional self-regulation, already a source of severe restrictions on various actors' competitive freedom. Thus, the occasion for my "trade-offs" article with Blumstein was the appearance of Professional Standards Review Organizations (PSROs), which Congress created in 1972 so that entities accountable to the medical profession could both set quality standards and define what services should be paid for under federal health programs. In addition, Bovbjerg and I published an article criticizing the decision of Congress to subject HMOs serving Medicare patients to the jurisdic-

¹⁴ Paul Starr, in an important 1982 prognostication, doubted that the market strategy would succeed as a public policy for the health care sector because it was unlikely to be implemented, even by the conservative Reagan administration, as a serious competitive strategy. PAUL STARR, *THE SOCIAL TRANSFORMATION OF AMERICAN MEDICINE* 419 (1982). *See also id.* at 442 (cautioning that competition among various types of corporate medical care is extraordinarily sensitive to the vagaries of politics). In a forthcoming article, I state,

To be sure, Starr might have said in 1982, with accuracy, that it was unrealistic for advocates of [market-oriented] policies to expect the American political and legal system to hit upon a clear, coherent policy and to execute it consistently. Those advocates might have replied, however, that such political realism, while generally warranted, constitutes a self-fulfilling prophecy that dooms the best ideas at the starting gate, ensuring that policies of all kinds will be second-best at best. If taken to heart, Starr's realism, born of observing organized medicine at work in many circumstances, would have forced would-be revolutionaries into self-imposed compromises with reactionary forces.

Starr on the Corporatization and Commodification of Health Care: The Sequel, 29 J. HEALTH POL., POL'Y & L. (forthcoming 2004). The cited article goes on to argue (in an implicit defense of my own revolutionary activities) that the market strategy was attractive and revolutionary enough that it deserved a chance to succeed, even against great political odds.

tion of PSROs, expressing the concern that, given authority over HMOs, professionalist PSROs would prevent them from providing useful competition for the fee-for-service sector. In general, the period was one in which it was sobering to bring political and economic insights from other regulated industries to bear on emerging federal and state policies in the health care sector.

Although I saw major problems with the regulatory approach, competition was not an entirely plausible alternative to regulation in the early 1970s because of the power that the organized medical profession exercised over many features of the system. The most immediate concern was the profession's ability to resist collectively any payer strategy that physicians did not like. Recognizing the importance of bringing antitrust law to bear on such professional dominance and obstructionism, I wrote a brief *amicus curiae* (pro se) in 1974 urging the Supreme Court to grant certiorari in the *Goldfarb* case, in which the lower court had refused to apply the Sherman Act to price fixing by lawyers in Virginia.¹⁵ My argument that the case was of crucial importance not only for the market for legal services but for the health care industry as well was certainly borne out by subsequent events. Together with several decisions extending the reach of the federal commerce power in markets for professional services, the Court's 1975 ruling that the "learned professions" enjoyed no exemption from antitrust law invited the antitrust enforcement agencies to challenge a variety of anti-competitive practices that had developed in medicine when antitrust law's applicability was unclear. Equally important, the availability of antitrust law to discipline providers made it much more realistic to contemplate a federal health policy relying heavily on competition. Indeed, in the late 1970s, the policy debate, which had previously been largely about whether the medical profession or government regulators should have the upper hand, began to recognize that there was a third way to tackle the nation's problem with rising health care costs. In the ensuing years, I was active in spelling out and advancing that policy agenda. In 1982, *Business Week* portrayed Ellwood, Alain Enthoven, Walter McClure, and me as a "Gang of Four" advocating a market-driven strategy.¹⁶

In 1978-79, I was again in Washington on a sabbatical leave, this time as a resident consultant at the Federal Trade Commission (FTC), which was actively considering how to enforce the antitrust laws in the health care sector. At that time, too, policy makers' interest in

¹⁵ *Goldfarb v. Va. State Bar*, 497 F.2d 1 (4th Cir. 1974), *rev'd*, 421 U.S. 773 (1975).

¹⁶ *The Spiraling Costs of Health Care – Rx: Competition*, BUS. WK., Feb. 8, 1982, at 58.

“deregulation,” which had gained significant traction in several previously regulated industries, finally began to extend explicitly to health care. In particular, the health sector attracted attention in the White House’s war against inflation, which was presided over by Alfred Kahn, famous for having dismantled the Civil Aeronautics Board. Significantly, in May 1979, Congress defeated the Carter administration’s centerpiece proposal to impose a national cap on the growth of hospital revenues, thereby signifying that it was giving up on trying to regulate private health care costs. Members also began to think and talk openly about a market-oriented health policy and to propose measures to strengthen competition in health care. In addition to participating in debates over hospital regulation, I had a significant role in helping Congress prepare the 1979 amendments to the 1974 health planning legislation.¹⁷ Those amendments included language, which I helped to draft, that for the first time expressed a favorable congressional view of competition’s potential in the health care sector. I described the flow and ebb of health planning and CON regulation in (among other places) a 1982 book, *Deregulating the Health Care Industry: Planning for Competition*.

An important theme in my work in the late 1970s and early 1980s was the potential for the private sector to bring some rationality to health care spending. In testimony prepared in 1976 for the Council on Wage and Price Stability,¹⁸ I observed, as others were beginning to do, how the tax treatment of employer-purchased health insurance induced over-insurance, greatly expanding the range of services subject to moral hazard and diminishing the returns from cost-containment efforts that private payers might undertake. In that statement and later writings (some of them co-authored with Glenn Hackbarth, a former student and later a colleague in Duke’s on-going Program on Legal Issues in Health Care), I attempted to envision cost-containment tactics that private payers might employ but had not to date employed—seemingly because (1) the tax subsidy diminished their incentive to do so, (2) the medical profession threatened to boycott any payer that infringed professional prerogatives, and (3) competition had not yet pushed payers to take active responsibility for controlling costs. Among other things, I insisted that any payer—conventional insurers as well as HMOs and other so-called “alternative delivery systems”—could both obtain competitive prices from

¹⁷ Health Planning and Resources Development Amendments of 1979, Pub. L. No. 96-79, 93 Stat. 592 (1979).

¹⁸ See Clark C. Havighurst, *Controlling Health Care Costs: Strengthening the Private Sector’s Hand*, 1 J. HEALTH POL. POL’Y & L. 471 (1977).

providers and address the moral hazard problem by bargaining directly with providers over prices and methods of rationalizing the utilization of services. In these articles observing opportunities for "private cost containment," I advocated discarding the old notion, fortunately embodied more in general practice (reflecting professional preference) than in law, that health insurers should underwrite a patient's access to any provider he might choose.¹⁹ In other writings during this period, I highlighted the trade restraints by which organized medicine had precluded health plans from assuming responsibility for the cost of care. I also take credit for stimulating two FTC economists, Lawrence Goldberg and Warren Greenberg, to write a much-cited article in which they analyzed the record in an early, unsuccessful antitrust case against the Oregon State Medical Society,²⁰ forcefully demonstrating how medical interests effectively stifled some promising early innovations in prepaid health care.²¹

As it turned out, selective contracting and preferred-provider arrangements finally became standard practice in the industry in the 1980s. What turned the tide was, first, an important FTC action challenging not only professional restraints on physician advertising but also ethical rules precluding so-called "contract practice."²² Second, the Reagan administration's decisive rejection of a regulatory agenda sent employers and health insurers a clear message that private health care costs would henceforth be their responsibility, not the federal government's. At the same time, the administration shifted to prospective payment for hospital services under Medicare, setting an impressive example in aggressive "prudent purchasing" for the private sector to follow. Developments on the private sector's demand side then quickly disproved the claim that only regulation could check growth on the supply side and otherwise control costs.²³ As I had

¹⁹ See Charles D. Weller, "Free Choice" as a Restraint of Trade in American Health Care Delivery and Insurance, 69 IOWA L. REV. 1351 (1984) (discussing how the AMA's "free choice" ethics effectively eliminates competition and the right of a patient to choose a physician). Over the years, I have frequently shared thoughts with Weller, an early and influential antitrust crusader against professional restraints in health care.

²⁰ United States v. Or. State Med. Soc'y, 343 U.S. 326 (1952).

²¹ Lawrence Goldberg & Warren Greenberg, *The Effect of Physician-Controlled Health Insurance*: U.S. v. Or. State Med. Soc'y, 2 J. HEALTH POL. POL'Y & L. 48 (1977).

²² AMA v. FTC, 638 F.2d 443 (2d Cir. 1980), *aff'd by equally divided Court*, 455 U.S. 1744 (1982).

²³ After these claims were discredited, regulation could be defended only on the expedient ground that price competition would undermine the capacity of certain providers, especially hospitals, to cross-subsidize activities for which insurance was not available to pay. In addition to escaping accountability of public financing

argued in the *Virginia Law Review* in 1973, regulation had been aimed only at suppressing the symptoms of a seriously dysfunctional payment system, a strategy favored by industry interests precisely because it gave the impression of control while protecting incumbent payers and providers against pressures to change appreciably the ways they did business. In the new era, even Blue Cross and Blue Shield plans were soon forced by competition to act as purchasing agents for consumers, rather than as friendly selling agents for organized providers.

By the mid-1980s, I had begun to believe that a true revolution was in progress in American health care, one that would ultimately give consumers effective agents through whom to confront previously dominant providers and thereby obtain the benefits of both price competition and provider accountability for wasteful or unwanted spending. Advancing this revolutionary cause required, among other things, scholarly attention to the problem of applying conventional antitrust doctrine to an industry whose services were generally financed through insurance and that appeared to many to be so qualitatively different from other competitive industries as to require special, softer antitrust rules. Accordingly, I wrote numerous articles attempting to clarify the application of antitrust principles to a wide variety of professional activities, including the administration of staff privileges in hospitals, peer review, personnel credentialing, technology assessment, and the accrediting of institutions and educational programs. On the last of these topics, I edited a 1994 symposium in *L&CP* entitled "Private Accreditation in the Regulatory State." Although my work on antitrust issues normally tended to favor aggressive enforcement against professionals, a talk and an article written in 1995 were somewhat critical of the enforcement agencies' policy in evaluating physician networks. Presumably because I was known as a critic of the profession, the American Medical Association featured my views on this subject in a full-page ad in the *New York Times*.²⁴

This is not the place to recount the successes and failures of the antitrust campaign. To be sure, lower courts still tend to be soft on many types of professional restraints, and a bare majority of the Supreme Court was shockingly so in *California Dental Association v. FTC*.²⁵ But for the most part antitrust principles have been adapted to

through the political process, however, such backdoor financing invites inefficient operation and the provision of services that are not valuable enough to justify public support.

²⁴ N.Y. TIMES, Nov. 17, 1995, at A11.

²⁵ 526 U.S. 756 (1999) (raising standard of proof needed to establish illegality of a professional association's restrictions on member advertising). My critique of

the health care field without appreciably relaxing the law's rigorous insistence on competition. In any event, I felt by the late 1980s that the antitrust mission of breaking the power of the medical monopoly was on its way to being accomplished fairly well, thus fulfilling a vital condition for the revolution's ultimate success. I was sufficiently encouraged that developments were progressing well in the direction of empowering consumers that I wrote a piece in 1986 cautiously heralding the revolution. Its title was "The Changing Locus of Decision Making in the Health Care Sector." Although that article spoke only of the "decentralization" of decision making, I finally broached the theme of actual revolution in a 1990 article, which I ended by observing a parallel between the fall of communism in Eastern Europe and the weakening of "the medical profession's one-party rule" in American health care.²⁶

Also in the mid-1980s, I felt that the legal environment of the health care industry had both changed and stabilized enough that it could be effectively and usefully captured and presented in a new law school casebook. In 1988, Foundation Press published the first edition of my *Health Care Law and Policy: Readings, Notes, and Questions*. Prepared single-handedly, the book appeared about one year after the multi-authored first casebook explicitly focused on "health law."²⁷ My book represented a greater departure from past texts, however, because it made relatively little effort to address the traditional issues falling under the heading of "bioethics" and instead focused explicitly on the industry's recent commercialization and the legal and policy issues raised by those developments. I also explicitly presented the trade-off problem early in the text, so that business practices and legal rules encountered later could be examined in part from an economic perspective. Moreover, instead of treating legal issues under legal headings, I presented them as they arose from industry practices, both past and present, or were suggested by emerging trends. Thus, I introduced the application of antitrust law to professional services fairly early in the course because the antitrust cases and developments teach so much—as they had taught me—about the industry's history and new competitive environment. Once the students had some basic antitrust knowledge, it was possible to address the antitrust issues raised by specific business practices, such as the

this decision appears as part of a short history in *Health Care as a (Big) Business: The Antitrust Response*, 26 J. HEALTH POL., POL'Y & L. 940, 949-53 (2001).

²⁶ *The Professional Paradigm of Medical Care: Obstacle to Decentralization*, 30 JURIMETRICS 415, 429 (1990).

²⁷ BARRY R. FURROW ET AL., *HEALTH LAW: CASES, MATERIALS AND PROBLEMS* (1st ed. 1987).

denial of hospital staff privileges, as they came up in context later in the course. Fortunately, I was able to persuade Jim Blumstein and Troy Brennan to assist me in preparing the book's second (and much improved) edition, which appeared in 1998. (A third edition is contemplated.) I regard the casebook as a scholarly, not just a pedagogical, contribution and wish that more colleagues in the field, including those who find the book too challenging for their students, would consult the book and the accompanying teacher's manual for conceptual guidance and insights.

Encouraged as I was about the revolution's progress in the early 1980s, I still saw obstacles to realizing its ultimate objective of empowering consumers. I worried, for example, that the intermediaries on whom consumers would have to rely to represent their interests in post-revolutionary markets did not have all the tools and freedom they would need to make and enforce difficult trade-offs in administering coverage in the interest of their subscribers. As early as 1983, in an article about what I saw as an emerging challenge to "the prevalent assumption that the health care system must operate under prescriptive standards of acceptable care and appropriate spending," I warned that would-be market reformers of the health care system "could go wrong . . . by assuming too readily that interacting private parties and institutions would be free and uninhibited in their competitive efforts to translate consumer cost concerns into economizing behavior by providers."²⁸ That article opened up a scholarly agenda that engaged me on and off well into the 1990s. Specifically, it raised doubts about the flexibility and utility of private contracts as vehicles for introducing alternative standards, rights, and obligations in the health care field. The problem was not just explicit regulation, which by that time was largely on the run. Instead, as I observed,

[d]octrines of *private* law—the law of torts and contracts—may impose on private parties duties that are inconsistent with both efficiency and the parties' contractually specified obligations. If such legal doctrines, originally designed to prevent economically powerful interests from overreaching the consumer, stand in the way of departures from prevailing standards of care and practice in the medical care field, market re-

²⁸ Clark C. Havighurst, *Decentralizing Decision Making: Private Contract Versus Professional Norms*, in *MARKET REFORMS IN HEALTH CARE: CURRENT ISSUES, NEW DIRECTIONS, STRATEGIC DECISIONS* 22, 22 (Jack A. Meyers ed., 1983).

formers' hopes of seeing consumers offered a full range of choice are doomed to frustration.²⁹

I noted the irony that paradigms and legal doctrines ostensibly designed to protect consumers against "economically powerful interests" might prove instrumental in frustrating the movement to empower consumers against the powerful dictates of both medicine and the legal system, thereby perpetuating what I called "The Tyranny of Professional Norms and Standards."³⁰

A related obstacle to the revolution's ultimate success was the professional paradigm of medical care, which rejected the possibility that health care might become a true consumer good in the sense that people could purchase just the quantity (intensity) and quality of it that they desired and could (with available subsidies) afford. In the early 1980s, however, it began to seem that the paradigm might topple. At that time, the work of John Wennberg³¹ and David Eddy³² made the policy community suddenly aware of unexplained variations in medical practice and of the weak scientific foundation for many services that doctors customarily prescribe. To my eye, these findings revealed fundamental flaws in the professional paradigm, founded as it was on trusting clinicians to translate scientific learning into sound clinical policies. To my ear, they cried out for giving health plans some freedom to set their own practice standards, rather than being forced to pay for whatever some medical expert, consulting "professional standards," might declare to be "medically necessary." What ensued, of course, was a campaign by organized medicine to reestablish its credibility and maintain its authority over medical practice by producing "clinical practice guidelines." But the new shakiness of professional authority made it possible to imagine that the "locus of decision making" might really shift decisively in the direction of consumers.

In the middle of the 1980s, a new malpractice "crisis" attracted legislative interest and occupied the time of many of us in the field of health care law. Consistent with my view that people should be reasonably free to choose the rules under which they receive professional services, I wrote some articles promoting "private" malpractice reform—that is, contractual (rather than legislative or judicial) modifi-

²⁹ *Id.* at 23 (emphasis added).

³⁰ *Id.*

³¹ E.g., John E. Wennberg, *Dealing with Medical Practice Variations: A Proposal for Action*, HEALTH AFF., Summer 1984, at 6.

³² E.g., David M. Eddy, *Clinical Policies and the Quality of Clinical Practice*, 307 NEW ENG. J. MED. 343, 343 (1982) (finding reason to believe that there are flaws in the process by which the profession generates clinical policies).

cations of patients' rights and providers' obligations under the law of torts. A major conference that Bovbjerg and I ran in Washington in 1985 and turned into a 1986 volume of *L&CP* focused substantially on the potential for private reform, under the subtitle "Can the Private Sector Find Relief?" My two articles in that symposium sought not only to push the idea of contractual reform well beyond arbitration clauses, the only place it had been favorably received, but also to connect thoughts expressed by Richard Epstein in the 1970s³³ to trends in modern health policy. One idea that still seems wise, though it has had few takers, was that new rules governing medical injuries, instead of being built into provider/patient contracts, should appear in the subscriber contracts of competing health plans. Indeed, I went so far as to suggest, among other things, that consumers might be offered contracts establishing a standard of care different from the costly professional one embodied in malpractice doctrine and drawn principally from customary medical practice. As I argued in a 1991 article, again in *L&CP*, the new availability of practice guidelines made this strategy much more feasible than it would have been in earlier times.

Few of my projects have yielded less in terms of opening up new policy possibilities than my efforts on behalf of contractual reform of malpractice law. In retrospect, I can see how naive I was to think that the legal monopoly, however much valid criticism it attracted, would ever allow people to reject the rights it confers on them in favor of something less costly. But it was my first direct encounter with the power of the rights-based legal paradigm and of the trial lawyers who defend it. Perhaps most surprising to me was to see how few of my colleagues in the legal academy showed any enthusiasm for contesting the legal system's monopoly over the rules governing medical injuries. The majority seemed entirely comfortable with the idea that the legal system is well-positioned to know what is good for people and that, if change is to occur, it must come from within the legal system itself, not from people choosing for themselves. Indeed, many who had seemed to share my view that the medical profession should not dominate decision making in the health care field had no similar reservations about a legal system that aggressively monopolizes the making of consequential choices. I sense that many academic lawyers are threatened by market-oriented ideas in part because they value their role as minor cogs in the machine that grinds out the rules by which people are required to live.

³³ Richard A. Epstein, *Medical Malpractice: The Case for Contract*, 1976 AM. B. FOUND. RES. J. 87.

In 1989-90, I was on another sabbatical leave in Washington, this time working as a part-time consultant in the offices of Epstein, Becker & Green. Although the first Bush administration was a disappointment to anyone who hoped to see renewed attention to health policy, the practice guidelines movement was then entering a crucial phase. During that year, I spoke and wrote (in the *St. Louis University Law Journal*) approvingly of the medical profession's efforts to develop guidelines. I also argued, however, that useful guidelines might emanate from independent sources and be more prescriptive than the profession would like. I also advanced the heretical view that an individual health plan should be free to select the particular guidelines by which it expected its doctors to abide. Indeed, I viewed guidelines as a new technology that might finally enable a health plan to specify in its contracts with subscribers just what services it and its providers would undertake to cover or provide in particular clinical circumstances. Suddenly, I thought, health plans had the capability of offering consumers real, explicit alternatives, some with price tags much less burdensome than the cost of care prescribed according to professional standards. Much of my work in the early 1990s was aimed at promoting the use of creative contracts in aid of consumer economizing. A 1992 article, for example, was entitled, "Prospective Self-Denial: Can Consumers Contract Today to Accept Health Care Rationing Tomorrow?"

Just as there were few takers for the idea of private malpractice reform, most of the legal academy and the lawyers who advise health plans apparently saw little merit (or promise) in my more general proposals to empower consumers of health care by widening freedom of contract. My 1995 book published by AEI Press, *Health Care Choices: Private Contracts as Instruments of Health Reform*, attempted to show why current health contracts are burdensome to individuals, how better contracts could be written, and why, with public subsidies and normal legal protections, consumers would not be at undue risk if health care finally became a true consumer good. The book also recounted my effort to persuade the Clinton administration's task force on health reform to incorporate a substantial role for private contracts in the legislation it was preparing. Although my ideas found some sympathetic ears among task force members, egalitarian impulses were too strong at the task force's top, and the principles of "managed competition," as developed by Enthoven and the Jackson Hole Group, were largely sacrificed in favor of a regulatory agenda. I still believe, however, that adopting my suggestions would have made the reform package more palatable to the voting public than the administration's proposals turned out to be. In any event, reform-by-contract remains available as a practical and reasonable

way of finally realizing the goal of universal health coverage at affordable prices. To date, however, private contract has not proved an effective vehicle for empowering consumers in the health care marketplace. In a 2000 commentary on how professional standards and not consumers' choices continue to drive the system, I observed the irony "that the same legal system that with one arm launched an anti-trust initiative successfully challenging overt efforts by the medical profession to exercise decision-making authority in the health care sector has, through its other arms, conferred on medical interests a highly effective monopoly over the most important economic decisions affecting American health care."³⁴

My most recent work has, like this essay, been largely retrospective, aimed at helping the policy community understand why two decades of relying principally on market forces in health care, although triggering a promising movement toward managed care, have not turned out well. A symposium I edited for *L&CP* in 2002 posed the question, "Is the Health Care Revolution Finished?" Unfortunately, my answer to that question is affirmative, not because the revolution had nothing more to offer but because it has been effectively rolled back by its opponents. These opponents included, in addition to counter-revolutionary interests in the medical profession, many in the legal academy and policy community who also resist pluralism and are similarly unwilling to see health care issues resolved in the marketplace. My own article in that symposium was titled "How the Health Care Revolution Fell Short." Among other things, it explains how the managed care industry itself, behaving opportunistically and short-sightedly in a highly uncertain and changing political environment, failed to do its part. Specifically, I can now see why modern health plans ultimately failed (1) to effectively integrate the provision of health care with its financing and thus to manage trade-offs sensitively in the interest of their subscribers; (2) to offer consumers a full range of health care options, including not only expensive, ostensibly high-quality care and coverage but also appreciably cheaper versions of possibly lesser quality; and (3) to earn consumers' trust as their post-revolutionary representatives and allies in the battle against high health care costs and entrenched professional power.

One regret I have, looking back, is that I was not more attentive, or attentive at a much earlier date, to the problem of making health plans legally accountable when their enrollees fail to receive either the quantity or the quality of care they were promised. Possibly, for ex-

³⁴ Clark C. Havighurst, *American Health Care and the Law—We Need to Talk!*, *HEALTH AFF.*, July-Aug. 2000, at 84, 97.

ample, I should have joined the debate over the scope of federal preemption, under the Employee Retirement Income Security Act (ERISA),³⁵ of state remedies against health plans that fail to honor their contracts. To be sure, unlike my many colleagues who decried the protection that ERISA-protected health plans enjoyed against lawsuits for personal injuries caused by erroneous denials of coverage, I saw some benefit in leaving health plans free to address their moral hazard problems without the risk that they would be unreasonably second-guessed by state courts and juries. Moreover, I saw little convincing evidence, either in the cases I read or in the anecdotes reported in the press, that health plans, though sometimes wrong or inept in administering their coverage, were acting in bad faith or intentionally abusing their power to ration marginally beneficial care. But the situation was clearly less than ideal and deserved more attention than I gave it.

While I was probably right in my judgment that repealing ERISA to subject health plans to more legal deterrence of erroneous benefit determinations would have raised costs unjustifiably, I failed to anticipate how ERISA preemption of enrollees' legal remedies might distort the perspective and influence the behavior of the health plans themselves. With little to fear from personal-injury lawsuits, they paid less attention to building solid legal defenses for the methods they were using to control costs. Not only did health plans fail to turn square legal corners by writing contracts that explicitly authorized those methods and by candidly explaining them in sales literature and plan documents, but they appeared to conclude that they would stand or fall only according to standards set by the political system and by cost-conscious employers, their immediate customers. Macro-accountability to government and large group purchasers was an inadequate substitute, it seems, for micro-accountability to individual consumers and the courts. Indeed, as long as health plans are not effectively and reasonably accountable in a credible legal forum for the way they administer their contracts in specific cases, the legitimacy, and thus the efficacy, of contract itself, as a tool by which consumers can exercise real choice, will remain fundamentally in doubt. The alternative when contracts are not trusted is, of course, prescriptive regulation, which has been gradually reasserting itself as—in the absence of well-drafted, enforceable contracts—the legitimacy of managed care has been called into question. In a 2001 article in *Health Affairs*, I expressed mild approval of certain class actions that had been filed against managed-care firms. My thesis was that health

³⁵ 29 U.S.C. §§ 1003-1191 (2000).

plans deserved some sanction, not for using particular methods to ration care (as the plaintiffs maintained), but for inadequately disclosing those methods in their advertising, contracts, and other plan documents—that is, for hiding from their subscribers the de facto limits they were placing on patient entitlements.

The accountability of managed-care organizations has another important aspect as well, to which I gave substantial attention in the mid-1990s but which I now think I should have emphasized much sooner. To its credit, the Clinton health reform task force proposed the radical idea of extending the principle of “enterprise liability” to all managed-care organizations—that is, making the health plan exclusively responsible in law for the negligence of its affiliated providers. Although I had not previously focused on this issue, I supported the Clinton team’s idea both in meetings it convened and in legislative language I drafted for the task force’s consideration.³⁶ Subsequently, I refined my thinking in a pair of articles, finally concluding that “vicarious liability” is the preferable term and concept, because it preserves the notion that it is still medical professionals, not the corporate enterprise itself, whose performance is at issue. Indeed, the more I thought about it, the more strongly I believed that plan accountability for injuries caused by providers they selected is necessary to legitimize managed care and that its absence was a key factor in managed care’s downfall in the 1990s. In a 2000 article, I finally recognized what should have been obvious much sooner: the fundamental untenability and instability of a health policy under which “corporate health plans have assumed extensive responsibility for the cost of care without accepting more than nominal responsibility for its quality.”³⁷

In retrospect, I regret that I did not have vicarious liability on my reform agenda in the early 1980s, when, by better aligning the interests of plans and providers, it would have made a dramatic difference in the way plans evolved. Indeed, I now think it probable that vicarious liability would have promoted precisely the close integration of plans and providers that was rarely achieved but that is vital to improving quality and to efficiently and appropriately controlling cost. Unfortunately, my early faith that logic and market pressures to achieve efficiency would push health plans inexorably toward such integration (and the law in turn toward recognizing the new reality) took too little account of the staying power of the professional para-

³⁶ See CLARK C. HAVIGHURST, *HEALTH CARE CHOICES: PRIVATE CONTRACTS AS INSTRUMENTS OF HEALTH REFORM*, 59-60, 81-82 (1995).

³⁷ Clark C. Havighurst, *Vicarious Liability: Relocating Responsibility For the Quality of Medical Care*, 26 AM. J.L. & MED. 7, 13 (2000).

digm of medical care, which had long opposed anything that smacked of “corporate practice.” I simply failed to appreciate the need for legislation that would both legitimize and induce departures from the paradigm. Clearly, as a fomentor of the health care revolution in the 1980s, I was not radical enough.

Although the revolution failed at many points to achieve its ambitious goal of empowering ordinary consumers in the face of entrenched interests, the ultimate problem—as I now conclude (and previously suspected, even while choosing not to give in to such a counsel of despair)—is the political economy of American health care law and policy. Whereas most analysts believe that health care markets are doomed to fail because consumers are ignorant concerning the quality of care, a much greater problem is consumers’ ignorance concerning the *cost* of their health coverage. At least in the private sector, this ignorance creates a special kind of moral hazard, which enables employers, government, and the legal system to freely (or almost freely) write costly prescriptions for which consumers must ultimately pay. Strikingly, the ignorance of consumers-*cum*-employees-*cum*-voters concerning the cost of the health care they enjoy is not inevitable. Indeed, it is instructive to consider just whose interests are served when government, by subsidizing health care indirectly through the tax system, ensures that its costs will be well hidden from those who pay them. My 2002 article in *L&CP* presents a model of majoritarian and interest-group politics that shows convincingly why the health care revolution never really had a chance. Specifically, it explains both the “over-regulation” of health care, that is, the bevy of cost-increasing legal requirements that benefit the majority at the expense of the (lower-income) minority—and its “hyper-regulation”—that is, requirements that, once hidden costs are counted, diminish the welfare of a *supermajority* of voters while yielding net benefits only to the health care industry and its upper-income patrons. To be sure, there were some years when the political cards were being reshuffled and revolutionary change seemed truly possible. But those cards are stacked again. Although I still feel a duty to advocate change that would empower consumers at the expense of special interests, I have fewer illusions than I used to have that market-based democracy will eventually prevail, enabling consumers to govern the system through their cost-conscious choices.

My latest work has also left me with a deeper appreciation of how the American health care system oppresses ordinary Americans. In addition to forcing them to contribute to financing a hyper-regulated system with marginal benefits far more costly than most of them would choose to pay for, the system is also, I now believe, scandalously regressive in the way it distributes its seemingly egalitarian

benefits. Among other likely sources of systematic regressivity—besides regulatory standards biased against middle- and lower-income premium-payers—are the following: employers' tendency to design benefits to serve the interests and preferences of their higher-income employees; providers' tendency to tailor clinical choices according to patient expectations, which may vary in proportion to income and education; discrepancies in the ability of higher- and lower-income patients to "work the system," especially now that consumers possess extensive appeal rights;³⁸ the probable disparate impact of cost sharing on high- and low-income individuals' consumption of insured services; and the way the tort system distributes its costs (equally) and benefits (unequally, at least insofar as it compensates for lost income). To be sure, empirical evidence is lacking concerning how much more, or less, care certain income groups consume than they pay for; indeed, one wonders why researchers have not studied such questions. But there are simply too many respects in which the American health care system appears to serve elite interests at the expense of the great majority of (ignorant) consumers/employees/voters, who are not only denied by law the chance to opt for cheap health coverage (with public subsidies ensuring basic adequacy) but often forced by the high cost to forgo health coverage altogether.

My son, preparing for a test in middle school, once asked me to define "economics." My answer, "the study of scarcity," earned him no credit with his teacher. Likewise, my idea that public policy should view health care as a scarce resource, like other consumer goods, has been widely deemed politically incorrect in the legal academy. That, at least, is the conclusion I have drawn from seeing how skeptically my work embodying that idea has been received by many health law scholars. I have always understood, of course, why the explicitly political world, which trades in symbolism and populist appeals to voters' apparent self-interest, finds it impossible to acknowledge that health care, because its costs frequently exceed its probable (though seldom its hypothesized) benefits, should sometimes be unavailable to people seemingly in need of it. But the rest of the legal world in general, and academic lawyers in particular, have no comparable excuse for resisting the notion that individuals, appropriately subsidized by society, should be allowed to choose their health care—and, if they see fit, to economize by agreeing in advance to

³⁸ See, e.g., *Rush Prudential HMO, Inc. v. Moran*, 122 U.S. 2151 (2002) (allowing HMO member to obtain at plan expense, through perseverance and protracted litigation, costly services that other plan members, paying the same premiums, would have had no realistic prospect of receiving in similar circumstances).

forgo marginally valuable services. I find it ironic that so many who think of themselves as progressives can dismiss my ideas so easily, even when I am expressing concern about the welfare—not just the health care, to be sure—of the very people they profess to care about most.³⁹ The crowning irony, for me, is that, while many scholars seem to marginalize me as a conservative, I have been more accurately characterized as “a radical” who “take[s] consumers’ rights seriously.”⁴⁰

In any event, it has been a privilege to spend a career worrying, as conscientiously and constructively as I know how, about issues as consequential as those encountered in health care law and policy. Even though I regret that the nation has not embraced the democratic idea that people should be free, trusted, and expected to choose for themselves (above a floor guaranteed by public subsidies) the health care that best suits their circumstances, I remain encouraged that the nation has not definitively taken a different policy direction. Instead, national health policy has become mostly incoherent, just as health care law remains, as I explained in a 2000 overview, a mass of “anomalies and fundamental contradictions [that] reflect a high degree of cognitive dissonance both in public attitudes toward health care and in health policy itself.”⁴¹ Under such unsettled and unstable circumstances—and with the uninsured a matter of continuing, even increasing, concern—it is not unreasonable to think that dramatic happenings, both in the private sector and in the political sphere, will eventually reopen the search for ways to put American health care finally on a sound economic footing while also honoring a commitment to ensure everyone a reasonable minimum level of care. Because cost-

³⁹ Just after writing this thought (and the previous paragraph), I was struck by the following from a review of a recent book by a respected political scientist: “Her rebuke to today’s liberals is that while they don the mantle of democratic egalitarianism, they actually represent the outlook of upper-middle-class elites who have decoupled their policy agenda from the concrete interests of the lower-middle class and the working poor.” William A. Galston, *The New Class vs. Social Democracy*, PUB. INT., Fall 2003, at 100, 102 (reviewing THEDA SKOCPOL, *DIMINISHED DEMOCRACY: FROM MEMBERSHIP TO MANAGEMENT IN AMERICAN CIVIC LIFE* (2003)).

⁴⁰ See James C. Robinson, *Taking Consumers’ Rights Seriously*, HEALTH AFF., Fall 1996, at 277 (reviewing my book, *Health Care Choices*):

Clark Havighurst is a radical. His new book . . . rages like the rivers Alpheus and Peneus through the Augean stables of health policy discourse, filled as they are with intellectual leavings of medical, legal, and bureaucratic elites that for decades have denied consumers their rights under the pretense of promoting those rights and enfeebled the citizenry under the pretense of protecting it.

Until I read Professor Robinson’s striking simile, I had never thought of the task I set for myself as Herculean.

⁴¹ Havighurst, *supra* note 34, at 86.

constrained consumer choice is still the most promising, practical, and democratic tool we have for breaking the hammerlock of unrealistic, legally guaranteed entitlements and for making both private health coverage and publicly financed universal coverage affordable, the time may eventually come for ideas like mine—unthinkable as they still seem to be for many observers.⁴²

⁴² Perhaps, however, what we have witnessed in the last thirty years is an example of the cyclical nature, observed by Calabresi and Bobbitt, of public policies affecting so-called tragic choices. GUIDO CALABRESI & PHILIP BOBBITT, *TRAGIC CHOICES* (1978). Their insightful observation was that there are some situations (tragic choices) in which, even though economic efficiency may clearly dictate that unlucky individuals should bear some serious hardships rather than having them prevented or alleviated by public action, our political and legal institutions cannot, and will not, indefinitely accept such apparently avoidable tragedies. In their view, public policy in such cases is destined to evolve endlessly in cycles, emphasizing at each stage some value—efficiency, compassion, fairness, or openness, for example, that previous policy had neglected. I wonder if other scholars working in the health policy field feel diminished, as I do, by the possibility that we are only playing transitory roles in an unending drama that has no denouement, only scenes that, however satisfyingly or unsatisfyingly any one of them may end, leave the policy result still unsettled and unstable. Is it true, as the Calabresi/Bobbitt hypothesis suggests, that seriously consequential choices can never be permanently removed from the public agenda and placed finally (with subsidies) in private hands? Although I am not convinced that things are necessarily that way in health policy, recent events and many aspects of the political economy of health care certainly suggest that we may never get health policy right.